

KENTUCKY BOARD OF EMERGENCY MEDICAL SERVICES
EMT BASIC
MINIMUM CONTINUING EDUCATION REQUIREMENTS
TOTAL CONTACT HOURS: 24
(ADDITIONAL TO CPR AND VERIFICATION OF SKILLS MAINTENANCE)

SECTION I – EMT-BASIC REFRESHER TRAINING

| | |
|---|---------------------|
| DISASTER MANAGEMENT OR MASS CASUALTY INCIDENTS | 1 HOUR TOTAL |
| AIRWAY | |
| 1. AIRWAY MANAGEMENT | 2 HOURS TOTAL |
| PATIENT ASSESSMENT | 3 HOURS TOTAL |
| 1. MEDICAL ASSESSMENT | |
| 2. TRAUMA ASSESSMENT | |
| 3. DOCUMENTATION/REPORTS (COMMUNICATION) | |
| MEDICAL/BEHAVIORAL EMERGENCIES | 4 HOURS TOTAL |
| 1. RESPIRATORY EMERGENCIES – 1 HOUR MANDATORY | |
| 2. CARDIAC EMERGENCIES – 1 HOUR MANDATORY | |
| ELECTIVES - 2 HOURS | |
| 3. GENERAL PHARMACOLOGY | |
| 4. DIABETIC EMERGENCIES | |
| 5. ALLERGIC REACTIONS | |
| 6. POISONING & OVERDOSE | |
| 7. ENVIRONMENTAL EMERGENCIES | |
| 8. BEHAVIORAL EMERGENCIES | |
| TRAUMA | 4 HOURS TOTAL |
| 1. BLEEDING, SHOCK & SOFT TISSUE INJURIES | |
| 2. MUSCULOSKELETAL INJURIES | |
| 3. INJURIES TO THE HEAD & SPINE | |
| O.B. (GYN), INFANTS AND CHILDREN | 2 HOURS TOTAL |
| 1. O.B./GYN | |
| 2. INFANTS & CHILDREN | |
| GENERAL ELECTIVES (OTHER SUBJECTS NOT COVERED ABOVE) | 8 HOURS TOTAL |
| EXAMPLES: | |
| 1. OPERATIONS: - RESCUE | |
| - SPECIAL -HAZARDOUS MATERIALS | |
| -MASS CASUALTY INCIDENTS | |
| 2. ADVANCED AIRWAY MANAGEMENT | |
| 3. JURISDICTIONAL ISSUES/SERVICE SPECIFIC | |
| - FARM RESCUE | |
| 4. COMMUNICABLE DISEASES | |

SECTION II – C.P.R./EVIDENCE OF CURRENT TRAINING (BLS PROFESSIONAL LEVEL)

NOTE* All may be completed in a D.O.T./Standardized (KY or other State), structured EMT-B “Refresher Course”, or as individual Modules such that when totaled result in the components of an EMT-B “Refresher Course”.

**EMT-BASIC RECERTIFICATION REPORT
(FOR THE NON-REGISTERED EMT-B)**

| SECTION 1: EMT-BASIC REFRESHER TRAINING – 24 hours* | | | | | | | |
|---|------------------|-------------|----------------|------|-------------------------|--------------------|-----------|
| *Certification of completion of the 1994 National Standard EMT Basic Refresher Course | | | | | | | |
| DATE | DIVISION | MAND. HOURS | HOURS RECEIVED | DATE | DIVISION | MAND. HOURS | RECEIVED |
| | Disaster Mangmnt | 1 | | | Trauma | 4 | |
| | Airway | 2 | | | O.B. Infants & children | 2 | |
| | Pt. Assessment | 3 | | | Electives | 8 | |
| | Med/Behavioral | 4 | | | | | |
| | | | | | | TOTAL HOURS | 24 |

**Must provide current HIV/AIDS certificate with KY CHS Approval #

| SECTION II: CPR*(SUBMIT COPY OF CPR CARD OR VERIFY WITH APPROPRIATE SIGNATURE BELOW) | | | |
|---|---|------|-----------------|
| As the applicant's CPR instructor/training officer, I hereby verify the applicant has been examined and performed satisfactorily so as to be deemed competent in each of the following: | | | |
| Adult: | | | |
| 1 & 2 Rescuer | | | |
| CPR | | | |
| Obstructed Airway | | | |
| / / | | | |
| Child: | CPR Instructor/Training Officer Signature | Date | Expiration Date |
| 1 & 2 Rescuer | | | |
| CPR | | | |
| Obstructed Airway | | | |
| / | | | |
| Infant: | Printed Name of CPR Instructor/Training Officer Signature | | Training Agency |
| CPR | | | |
| Obstructed Airway | | | |

| SECTION III: VERIFICATION OF SKILL MAINTENANCE (INDICATE METHOD USED) | Q/A* Q/I* | DIRECT OBSERVATION | (EXAM) OTHER METHOD |
|---|----------------------|-------------------------------|------------------------------------|
| 1. PATIENT ASSESSMENT/MANAGEMENT: Medical & Trauma | | | |
| 2. VENTILATORY MANAGEMENT SKILLS/KNOWLEDGE: Simple adjuncts Supplemental Oxygen Delivery Bag Valve-Mask One-rescuer Two-rescuer | | | |
| 3. CARDIAC ARREST MANAGEMENT: Automated External Defibrillator (AED) | | | |
| 4. HEMORRHAGE CONTROL & SPLINTING PROCEDURES | | | |
| 5. SPINAL IMMOBILIZATION: Seated and lying patients | | | |
| 6. OB/GYNECOLOGIC SKILLS/KNOWLEDGE | | | |
| 7. OTHER RELATED SKILLS/KNOWLEDGE: Radio communications Report writing & documentation | | | |

Q/A* Quality Assessment ; Q/I Quality Improvement*

As the EMT-Basic Training Program Director, Service Director of Training/Operations or the Physician Medical Director of Training Operations, I do hereby affix my signature attesting to continued competence in all skills outlined in Section III.

PRINTED NAME

SIGNATURE

Training Program Director*, Service Director of Operations* or Physician Medical Director*

Title (Clarify if title is other than provided by examples)

Name of Agency Represented by Director or Other Title Phone # for contact between 8-4:30 pm Date
(Note: If the Director is a renewal candidate, they may not sign for themselves.)*

I hereby affirm that all statements on this EMT-Basic (Renewal) Report are true and correct, including the copied cards, certificates and other required verification. It is understood that false statements or documents may be sufficient cause for revocations by the Cabinet for Health Services – EMS Branch. It is also understood that the KY EMS Branch may conduct an audit of the renewal verification records listed at any time.

Printed Name of Renewal Candidate Signature KY EMT-B Cert. # Date